Final Agency Decision
15-0900-16905-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Edina Care and Rehab Center, Abbreviated Survey Exit Date September 5, 2005

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Beverly Jones Heydinger on March 9, 2006, at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, MN 55401. The meeting concluded on that date.

Appearances: Marci Martinson and Mary Cahill, Division of Facility and Provider Compliance, Department of Health (Department), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970. Susan Voigt, Esq., Voigt, Jensen & Klegon, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN 55114, on behalf of Edina Care and Rehab Center (Facility). Todd Carsen, Executive Director, Jonathon Torralba, Director of Nursing, Linda Rosecke, Clinical Nurse Consultant, David Halvorson, Licensed Practical Nurse, and Peggy Murray, Licensed Practical Nurse, also participated on behalf of Edina Care and Rehab Center.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION:

1. That citation F-157 be upheld.

2. That citation F-309 be upheld.

Dated this 20th day of March, 2006.

/s/ Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

Recorded: Tape-recorded
(Two tapes, No transcript prepared)

MEMORANDUM

The Department conducted an investigation after receiving a complaint concerning the Facility's care of Resident #1 on July 17 and 18, 2005. In the course of its investigation, the surveyors reviewed the Facility's policies and the documentation concerning Resident #1's care. In addition, the Department investigators interviewed a number of facility staff and the nurse practitioner who was contacted for direction concerning Resident #1's care.

Citation F-309

Federal regulations require that a facility must provide the necessary care and services for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with a comprehensive assessment and plan of care.[1] In response to a complaint, the surveyor will check to determine that a resident is receiving care that is designed to ensure optimal improvement, and prevents unnecessary deterioration, within the limits of the resident's medical condition and ordinary aging process. Where there was a lack of improvement or a decline, as in this case, the surveyor will determine if there was an accurate and complete assessment of the resident, a care plan based on the assessment that was consistently implemented, and an evaluation of the results of interventions and revisions as needed. If all of those steps have been followed, the decline is considered to be unavoidable.

The Facility's position is that there was no significant change or decline in the Resident's condition on July 17 and 18, 2005 that should have alerted the staff to reassess him. The Department maintains that there were several changes that should have triggered a reassessment of the Resident's condition and call to the physician.

[1] 42 C.F.R. § 483.25.

Citation F-157

Federal regulations require that the resident's physician and family must be informed immediately if there is a significant change that affects the resident's physical, mental, or psychosocial status, such as a deterioration in health, mental, or psychosocial status with either life-threatening conditions or clinical complications, and the need to make a significant change in the resident's treatment.[2]

The Facility's position is that there was no significant change in the Resident's status, and no additional notice to the physician or family was required. The Department contends that the geriatric nurse practitioner was not kept fully informed of the resident's declining status. Both the Facility and the Department point to the daily progress notes in support of their position.

Discussion

The facts concerning this Resident's care are applicable to both citations, and are addressed together. The Resident had lived at the Facility for about five years. He had a history of stroke, high blood pressure, congestive heart failure and difficulty swallowing.[3] The Resident was non-ambulatory, but alert and able to verbalize his needs. He was on a bowel program that included oral medications and tap water enemas every other day. The Resident had difficulty swallowing, and he was on a soft diet. His care plan indicated that staff should monitor for coughing, difficulty swallowing, temperature spikes, ability to feed himself, and monitor his lungs daily. Staff were also to monitor the Resident for signs of constipation, impaction and diarrhea, and have his bowel sounds assessed when there was evidence of constipation, abdominal/rectal pain or distention, nausea and vomiting. The Resident's vital signs were to be checked, and he was to be monitored for pallor, nausea, lethargy, or respiratory distress, and have his extremities observed for impaired circulation.[4]

According to the Resident's care plan, the physician was to be notified of any change in the Resident's vital signs or change of status, and in particular, if the Resident had shortness of breath or dyspnea, signs of respiratory distress, pallor, nausea, lethargy or impaired circulation.[5] The Facility's standing order specified that the physician should be notified under certain circumstances, including shortness of breath, temperature of 101 degrees or lower if indicated, and significant change in oxygen saturation level.[6] The notification process required the Facility to contact a geriatric nurse practitioner who screened calls for the physician.

The nursing notes show no significant changes during May and June. The only reference to symptoms is the wife's expressed concern on May 31, 2005 that her husband was not eating well and having difficulty swallowing. The Facility notified the

[2] 42 C.F.R. § 483.25.
[3] Dept. Ex. D-1.
[4] Dept. Ex. D-19, 20, 30, 31; Fac. Ex. 8.
[5] Dept. Exs. D-20, 138-a.
[6] Dept. Ex. 55a.

nurse practitioner.[7] When the nurse practitioner saw the Resident on June 1, 2005, she checked him, and he denied having pain or trouble swallowing. The only change the nurse practitioner made in his care was to take him off regular oxygen.[8] A staff member checked to see if the oxygen level should be maintained above 90 percent, but was directed to supplement with oxygen only if the resident was short of breath or for dyspnea, or complained that he was.[9] A notation on June 4, 2005 states that the Resident had no complaints of shortness of breath, no apparent dyspnea, choking or coughing, nor is there any reference to any of those problems during June. A care conference was held on June 28, 2005, and no concerns about breathing, coughing, swallowing, oxygen level or other changes were noted, except for some apparent increase in memory loss and decrease in decision making.

The nurse practitioner saw the Resident on July 13, 2005. She checked the Resident's bowel sounds, weight and eating habits.[10] At that time, he had lost weight, but denied nausea, vomiting or diarrhea. He was alert. The resident's records show that his oxygen saturation levels rose and fell regularly between the low to mid 80 percent range to the mid 90 percent range.

There were frequent notations that the Resident refused the prescribed tap water enemas between July 3 and July 17, 2005.[11]

With one exception, there were no notations in the Resident's nursing notes of shortness of breath, coughing, difficulty swallowing, or vomiting from May until July 17, 2005.[12] On that date, the record demonstrates a significant change in condition. The Resident complained that he was having difficulty breathing and swallowing and coughed up phlegm often throughout the day. Oxygen was administered. At around 12:30 p.m., the Facility staff left a message for the nurse practitioner, and noted that she would respond the following day. There is no evidence that the Facility staff checked the Resident's lungs, bowel sounds, extremities, or otherwise completed the required assessment.

The Resident later complained that he did not feel well and felt short of breath. The Resident threw up after supper and after receiving his medication. Later in the evening, his temperature was elevated to 100.4. A Tylenol suppository was administered. Despite these changes from any entries in the prior weeks and the directions in the care plan, no registered nurse was asked to assess the Resident that day, and there was no call to the physician or nurse practitioner to discuss the changes. Although the Facility contends that an RN was not required to collect the necessary information and assess the Resident, there was no indication that an LPN completed an assessment.

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[7] Dept. Ex. D-35-b.
[8] Dept. Ex. D-35-b – D-36a; Facility Ex. 13.
[9] Dept. Ex. D-36a, entries for June 3, 2005.
[10] Dept. Ex. D-43; Fac. Ex. 13.
[11] Facility Ex. 12.
[12] Dept. Ex. D-36a – D-40b; the Resident had wheezing and shortness of breath on May 12, 2006.

At about 4:00 a.m. on July 18 the Resident had a large emesis of brown fecal–like matter. The LPN who checked the Resident was the supervisor on duty. There is no indication in the records that she checked the Resident's bowels or lungs, observed or palpitated his abdomen, noted his skin temperature or color, or checked his extremities.[13] During her interview, the LPN stated that she was not aware whether an RN was on duty at that time, but also she did not believe that the changes were significant for the Resident.[14] It is apparent from her statements to the interviewers that the LPN concluded that the emesis was a result of the staff's unwillingness to administer the tap water enemas to the Resident over several days. Nonetheless, the LPN left a voice mail at 4:30 a.m. for the nurse practitioner, and the nurse practitioner was updated when she called back in the morning between 8:00 and 9:00 a.m.

There is a dispute about whether the nurse practitioner was aware that the Resident was having trouble breathing and swallowing, but she ordered an x-ray of the lungs and a test of the Resident's urine. The nurse practitioner's prompt call early in the morning and the order for an x-ray corroborate the testimony of the nurse on duty that she updated the nurse practitioner. It is not clear precisely how much information the nurse practitioner was given, and whether she was aware that no RN had assessed the Resident, but she was called and updated. Whether the nurse practitioner should have done more is beyond the scope of this proceeding.

At around 3:00 p.m. that same day, the evening LPN reported for his shift. He had not seen the Resident in three days and noted that the Resident was tired and lethargic, pale and ashen, and did not feel like conversing. The family members believed that the Resident appeared weaker and the daughter and son-in-law asked the LPN if the Resident would live through the night. They were concerned that, although the Resident looked at them, he did not seem to be able to recognize them individually. The LPN reassured them that there was no obvious evidence that the Resident was near death. The Resident's skin was warm, and his vital signs were not significantly different. The Resident was up in his wheelchair, and the family members had encouraged the Resident to drink a can of Ensure. The Resident had eaten only ice cream for lunch, and at around 4:15, the LPN gave the Resident his medications crushed in applesauce. The Resident had trouble swallowing the applesauce and there was some respiratory congestion.[15]

At around 4:00 p.m., the Resident's oxygen saturation level had dropped to 76 percent, oxygen was administered, and the saturation level began to rise. Although the Resident did not have an order for oxygen at that time, the LPN did not check with an RN. In addition, the LPN administered the oxygen in a manner that was inconsistent with the Facility's standard practice. However, based on the record, one cannot conclude that the drop in the Resident's oxygen saturation level constituted a significant change. Although the saturation level dropped below 80 percent, regular monitoring during May showed that the Resident's oxygen saturation level routinely fell below 90

[13] Dept. Ex. 41-a.
[14] Dept. Ex. D-63, 66 and 67.
[15] Dept. Ex. D-41b, D-84, 93; Test. of D. Halverson.

percent to the low to mid 80 percent range and then returned to above 90 percent when oxygen was administered.[16] Thus, when the LPN identified that the saturation level had dipped, but steadily rose with the administration of oxygen, that was a repeated pattern for this resident.

The Resident was put to bed shortly after 4:00 p.m. The Resident's evening meal and dose of an antibiotic were withheld because of concern that the Resident would choke on the medication. In making the decision to withhold the medication, the LPN took into account that the chest x-ray had been negative, and the urine sample drawn at around 5:30 had been clear.[17] Despite the concern voiced by the family, the Resident's lethargy, pallor, relative lack of responsiveness, unwillingness to feed himself, difficulty swallowing and drop in oxygen saturation, the LPN did not request an assessment by an RN, or report to the nurse practitioner.

The LPN checked the Resident at several points during the evening in order to monitor the oxygen saturation level. The next significant change is charted at 10:00 p.m. The nurse arriving around that time was concerned, and the Resident's breathing and vital signs were checked. The LPN aroused the Resident and spoke to him.[18] The Resident was "very lethargic," his temperature was 98.4 degrees and his oxygen saturation level had risen to 97 percent. Despite the Resident's lethargy, and the reaction of the night nurse coming on duty, the LPN acknowledged that he did not feel that it was necessary to check with an RN or a physician. The Resident was checked at about 10:30 p.m. when his oxygen tank was refilled, with no apparent change. It is not clear whether the LPN attempted to arouse the Resident at that time. At approximately 11:15 p.m. on July 18, the Resident was unresponsive and he had some mottling of his skin. Immediately the staff took steps to call an ambulance, call the doctor and to notify the family. The Resident was taken to the hospital where he died on July 21, 2005. [19]

Based on the evidence presented, it is clear that there was significant change in circumstances on July 18, 2005. The record as a whole supports the conclusion that, although the LPNs were monitoring the Resident, they failed to conduct a complete assessment, check with an RN or call the nurse practitioner at several points. Although the nurse practitioner was called at 4:30 a.m., there was no assessment by an RN completed at that time. Thereafter, the noticeable lethargy, difficulty swallowing, congestion, ashen color, lack of appetite and verbalization were all changes noticed by both the family and the evening LPN but were not reported. Although an x-ray was taken of the Resident's lungs and his urine was tested, there was not a full assessment or call to the nurse practitioner after noon that day. In addition, although a drop in oxygen saturation level was not unusual for the Resident, and he did not appear to be suffering from any shortness of breath, the decision to put him on oxygen should have been reviewed with an RN, and an assessment conducted, in light of his lethargy, limited interaction with his family, and unwillingness to eat. Thus, the failure to assess the Resident's significant changes beginning on July 17 and continuing on July 18, and

[16] Facility Ex. 13
[17] Test. David Halverson; see also Test. of J. Torralba.
[18] Dept. Ex. D-86, Test. Of D. Halverson.
[19] Dept. Ex. D-41b; Test. Of D. Halverson.

the failure to contact the nurse practitioner during the afternoon of July 18, justifies upholding the two citations.

Although the Facility contends that the developments were not "changes" in Resident #1, the nursing notes present a different picture. At no time in May, June or July prior to July 17 do the nursing notes or nurse practitioner's notes reflect that the Resident had the number or type of symptoms or changes that occurred on July 17 and 18. It is likely, as the Facility asserted, that the Resident was steadily declining. Nonetheless, when the care plan directed that certain changes should trigger an assessment or a call to the physician, that plan should have been followed.

B.J.H.